MEDICAID AGREEMENT LETTER

DENTIST

I agree to provide eligible dental services to an average of two (2) Medicaid eligible clients per week. I recognize that this agreement will result in an increase in the Medicaid payment amount of 20% for services rendered on or after July 1, 1997, and that initially these payments will be made on a prospective basis based on my Medicaid payments for the previous quarter.

Payment of the additional 20% will begin for the payment cycle after this signed agreement has been received by the Bureau of Medicaid. Rural providers are not eligible for the additional 20% volume payment, they will receive an automatic 20% because they are providing services in a rural area.

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Dentist's Signature Date

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National Provider Identifier Number

ORAL SURGEON

I agree to have my name included on a referral list for Medicaid clients, and will accept Medicaid referrals. I understand that this agreement will result in a 20% increase on the Medicaid payment schedule for all Medicaid client services. Rural providers are not eligible for the additional 20% referral list payment, they will receive an automatic 20% because they are providing services in a rural area.

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Oral Surgeon's Signature Date

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National Provider Identifier Number

Please return signed form to:

Medicaid Provider Enrollment
Box 143106
Salt Lake City UT 84114-3106

Fax line 538-6805

IF YOU ARE NOT CURRENTLY A MEDICAID PROVIDER AND WISH TO APPLY TO BE ONE, PLEASE CALL the Medicaid Information Line: 538-6155 or 1-800-662-965.